Supreme Court, U.S.
FILED

AUG 19 2002

OFFICE OF THE CLERK

(3)

No. 02-117

In The

Supreme Court of the United States

October Term 2002

STATE OF MINNESOTA,

Petitioner,

v.

JOAN MARTIN, GUARDIAN AD LITEM
FOR TROY HOFF,

Respondent.

On Petition for a Writ of Certiorari
to the Minnesota Supreme Court

BRIEF OF SEVEN STATE MEDICAID AGENCIES AS AMICI CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI

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August 19, 2002

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BRIEF OF SEVEN STATE MEDICAID AGENCIES AS AMICI CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI

The State Medicaid agencies of Alabama, Hawaii, Kentucky, North Dakota, New Hampshire, Rhode Island, and Utah respectfully submit this brief amicus curiae in

support of the petition for a writ of certiorari in this case.[1] Letters indicating the consent of the parties to the filing of this brief have been filed with the Clerk.

INTEREST OF AMICI CURIAE

The seven States that join in this amicus brief all participate in the Medicaid program and are therefore subject to the requirement that a State Medicaid agency "take all reasonable measures" to seek reimbursement from third parties who may have a legal responsibility to pay for the health care and services provided to a Medicaid patient. Among other things, State Medicaid agencies are required to recover from third parties whose actions have led to the injury of a Medicaid recipient the costs of medical care arising from those injuries. States discharge that obligation in a variety of ways, including by placing a lien on potential personal injury settlements or awards in actions initiated by the Medicaid recipient against a third party tortfeasor.

The decision from the Minnesota Supreme Court prohibits that practice and would require an alternative means of cost recovery that is more expensive, less efficient, and ultimately not feasible in the great majority of cases. The decision also calls into question the federal government's instruction to States as to how tort recoveries are to be allocated between costs for medical care and other claims such as pain and suffering or lost wages. Because both of these issues raise important questions of statutory interpretation that state agencies routinely face in their administration of the Medicaid program, amici submit this brief to assist the Court in its consideration of the State of

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[1] Pursuant to Rule 37.6, amici states that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than amici, made a monetary contribution to the preparation or submission of this brief.

Minnesota's petition for certiorari in this case, and urge the Court to grant the petition and reverse.

REASONS FOR GRANTING THE PETITION

The petition asks the Court to address the interaction between several sections of Title XIX of the Social Security Act, which establishes a program of medical assistance ("Medicaid") for certain groups of persons with very low income and minimal resources. States design and operate their own programs subject to a variety of federal policies and conditions. Medicaid is financed by both federal and state funds according to a matching grant formula.

In the decision for which review is sought, the Minnesota Supreme Court held that certain state laws that had been enacted to comply with Medicaid's "third party liability" provisions were preempted by the general "anti-lien" provision in the same statute. The situation described in the question presented is not obscure, but one with which all State Medicaid agencies are familiar: the state program has incurred expenses in paying for the medical services provided to an accident victim, and the Medicaid recipient then secures a tort award or settlement from the liable third party. In many States, the Medicaid agency is entitled to reimbursement for those medical expenses by operation of law, whether by assignment, lien, subrogation or otherwise. Contrary to the decisions of several other courts—not to mention guidance from the federal agency tasked with oversight of the Medicaid program—the Minnesota court held the State's only recourse to recover its Medicaid costs (costs shared by the federal government) was to pursue in each case its own independent claim against a potentially liable third party for the costs of medical care provided to Medicaid recipients.

There is a critical need for guidance from this Court as to how the Medicaid statute's interrelated third party

liability, assignment of claims, and anti-lien provisions coexist. As has often been lamented, the Medicaid Act is an "enormously complicated program. The system is a web; a tug at one strand pulls on every other." *State of West Virginia v. United States Dep't of Health and Human Services*, 289 F.3d 281, 294 (4th Cir. 2002) (quoting *Stephenson v. Shalala*, 87 F.3d 350, 356 (9th Cir. 1996)); *see also Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) ("The Social Security Act is among the most intricate ever drafted by Congress."). Although currently the Minnesota court stands alone in its approach, the peculiar interpretation it adopts is more than certain to be advanced in other States, calling into question the practices that many States have adopted, and leaving States uncertain as to how to responsibly discharge their third party recovery obligations. In recent years, this Court has twice granted certiorari in similar situations involving a single state court's interpretation of the Social Security Act that would prohibit a practice common to many States. *See Wisconsin Dep't of Health and Family Servs. v. Blumer*, 615 N.W.2d 647 (Wis. Ct. App. 2000), *rev'd by* 534 U.S. 473 (2002); *Keffeler v. Department of Social and Health Servs.*, 32 P.3d 267 (Wash. 2001), *cert. granted*, 122 S. Ct. 2288 (2002). The same considerations apply here.

I. The Decision Below Creates Uncertainty In An Important Area of Medicaid Program Administration.

The issue of how a State Medicaid agency can proceed to recover its costs in cases where a third party tortfeasor is liable for the medical expenses of a Medicaid recipient implicates three separate sections of the Social Security Act: Sections 1902(a)(25), 1912, and 1917(a)(1)(A). Many state legislatures, three state high courts, and the federal agency that oversees the Medicaid program have interpreted those provisions harmoniously, giving full effect to Congress' directive both to recover

medical costs from liable third parties and to protect the property of the Medicaid recipient. The Minnesota Supreme Court, however, sees them as fundamentally in conflict and strikes a "balance" that, in many cases, will be expensive, administratively impractical, and counterproductive.

A. Medicaid's Third Party Liability Provisions

Shortly after the Medicaid program was established in 1965, Congress added Section 1902(a)(25) to Title XIX to require that a state or local Medicaid agency must "take all reasonable measures to ascertain the legal liabilities of third parties to pay for care and services . . . arising out of injury, disease, or disability" and to "seek reimbursement for such assistance to the extent of such legal liability." Social Security Amendments of 1967, § 229(a), Pub. L. No. 90-248, *codified as amended at* 42 U.S.C. § 1396a(a)(25)(A), (B). The provision was enacted after Congress observed that "many people need medical care because of an accident or illness for which someone else has fiscal liability; for example, . . . a party who is determined by a court to have legal liability." S. Rep. No. 90-744, *reprinted in* 1967 U.S.C.C.A.N. 2834, 3022. Its purpose was to "make certain that the State and the Federal Governments will receive proper reimbursement for medical assistance paid to an eligible person when such third-party liability exists."

The third party liability or "TPL" provisions were strengthened in 1985, when Section 1902(a)(25) was amended to require each State to submit a plan to the federal government that described how it would pursue TPL, and further required that the plan be integrated with the State's information systems for administering Medicaid. *See Consolidated Omnibus Budget Reconciliation Act of 1985*, Pub. L. 99-272, § 9503(a)(1), 100 Stat. 182. The accompanying legislative history explained that Congress was requiring States to be more active in pursuing TPL

because "Medicaid is intended to be the payor of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146, at 312, *reprinted in* 1986 U.S.C.C.A.N. 42, 179 (Petitioner's Appendix ("Pet. App.") at A-171).

A State's responsibility to pursue TPL is supported by Section 1912 of the Act, which conditions eligibility for medical assistance on the assignment to the State of "any rights . . . to payment for medical care from any third party." 42 U.S.C. § 1396k(a). The same section requires recipients to "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." SSA § 1912(a)(1)(C), 42 U.S.C. § 1396k(a)(1)(C). Although the provision was originally enacted as an option available to the State, Congress made it mandatory on all States in 1984. *See* Medicare and Medicaid Amendments of 1984, Pub. L. No. 98-369, § 2367(b), 98 Stat. 494, *codified as amended at* 42 U.S.C. § 1396a(a)(45).

Section 1912 further provides that:

> Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

SSA § 1912(b), 42 U.S.C. § 1396k(b).

In fulfillment of their obligations under these sections, States have enacted a variety of laws to ensure that they can recover the costs of medical expenses paid on behalf of Medicaid recipients from liable third parties. In the case of expenses arising from an injury or accident, States sometimes will initiate actions against third party tortfeasors pursuant to their assignment rights. However, in cases where actions may be initiated by the recipient, many States have also exercised the option to impose a lien or right of subrogation by operation of law, up to the amount of medical expenses that Medicaid has incurred.[2]

The amount recovered in any one case may be small in relation to a State's overall Medicaid budget, but overall TPL presents a substantial cost-sharing to both the state and federal governments. States are required to provide quarterly reports on their TPL programs to the Center for Medicare and Medicaid Services or "CMS," which is the agency within the U.S. Department of Health and Human Services

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[2] *See, e.g.,* Alaska Stat. § 47.05.070 *et seq.*; Ark. Code Ann. § 20-77-301 *et seq.*; Cal. Welf. & Inst. Code § 14124.70 *et seq.*; Colo. Rev. Stat. § 26-4-403(4)(a); Conn. Gen. Stat. Ann. § 17b-93(a); D.C. Code Ann. § 4-607; Fla. Stat. Ann. § 409.910; Ga. Code Ann. § 49-4-149; Haw. Rev. Stat. § 346-37; 305 Ill. Comp. Stat. 5/11-22; Ind. Code § 12-1-7-24.6; Iowa Code § 249A.6; Kan. Stat. Ann. § 39-709 *et seq.*; Ky. Rev. Stat. Ann. § 205.624; Me. Rev. Stat. Ann. tit. 22, § 14; Md. Code Ann., Health-Gen. I § 15-120; Mass. Ann. Laws ch. 18, § 5G; Mich. Stat. Ann. § 400.106; Miss. Code Ann. § 43-13-125; Mo. Rev. Stat. § 208.215; Mont. Rev. Code Ann. § 53-2-612; N.H. Rev. Stat. Ann. § 167.14-a; N.J. Stat. Ann. § 30:4D-7-1.b; N.Y. Soc. Serv. Law § 104b.1; N.D. Cent. Code § 50-24.1-02.2; Ohio Rev. Code Ann. § 5101.58; Okla. Stat. tit. 63, § 5051.1; Or. Rev. Stat. § 416.540(2); 62 Pa. Cons. Stat. § 1409; S.C. Code Ann. § 43.7.420; Utah Code Ann. § 26-19-5; 33 Va. Code Ann. § 1910; Wash. Rev. Code § 43.20B.060; W. Va. Code § 9-5-11(a); Wis. Stat. § 49.89; Wyo. Stat. Ann. § 42-4-202.

charged with federal oversight of the Medicaid program.[3] In fiscal year 2000, the most recent year for which data is available, State Medicaid agencies collected over $1.3 billion in TPL collections, of which some $235 million was a result of court judgment or settlements from a liability insurer. *See* Third Party Liability Information on Cost Avoidance and Collection, Part I, available at http://cms.hhs.gov/Medicaid/tpl/cstavoid.asp (last modified May 15, 2002).

B. Medicaid's Lien Provision

The petition asks the Court to consider whether the state laws that Minnesota enacted to fulfill its obligations under Sections 1902(a)(25) and 1912 are preempted by Section 1917 of the Act, which provides that with limited exception "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf[.]" 42 U.S.C. § 1396p(a)(1). That provision has been part of Title XIX since the program's inception, although in 1982 it was renumbered and amended to permit States to place liens on the real property of institutionalized Medicaid beneficiaries whom the State determined to be reasonably likely to remain in a nursing facility for the remainder of their lives. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 132(b), 96 Stat. 324 (1982), *codified as amended at* 42 U.S.C. § 1396p(a); S. Rep. 97-494(1), *reprinted in* 1982 U.S.C.C.A.N. 781, 813-14.

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[3] Prior to 2001, the agency was known as the Health Care Financing Administration ("HCFA"). For consistency, we refer to "CMS" even during the period when it was known as HCFA.

C. CMS's Interpretation Of These Provisions Is Contrary to That of the Minnesota Supreme Court

As the agency charged with federal oversight of the Medicaid program, CMS has addressed the interplay between the statute's TPL provisions and the lien provision on a number of occasions, and in each case it has confirmed the propriety of a State's placing a lien on a potential personal injury award or settlement, if state law permits.

In 1994, a CMS "regional identical letter," took the position that there was no conflict between Section 1917's prohibition on liens and Section 1925's obligation to use all reasonable methods to pursue third party liability as long as the lien was placed not on the Medicaid recipient's property but "rather is being placed upon the tortfeasor's . . . property or upon funds which are set aside to be used in a settlement of the litigation." The letter further explained that pursuant to the assignment of claims provision, the State had a claim "to the amount recovered by the recipient, even though [the State] may not have been a party to the litigation." Pet. App. A-235 to 236.

This position was reiterated two years later, when all State Medicaid Directors were informed by letter that:

> If State law permits, a State can place a lien upon a third party's property, as in a situation involving the property of a tortfeasor or defendant in a person injury suit, or upon funds which are set aside to be used in a settlement, but which have not yet become the property of the Medicaid applicant or recipient.
>
> Section 1917(a) precludes States from placing liens on an individual's property. However, because a potential personal injury settlement

> is not yet the plaintiff's property, it can be subject to a TPL lien. Also, proceeds placed in a trust are not the property of the individual, but belong to the trust. As such, a State could place a TPL lien on any proceeds in a trust which could be used to pay for medical care covered in the State's plan, provided there were State laws allowing this.
>
> To avoid the lien issue, but protect its rights, a State could come to an agreement with a plaintiff on the settlement of a tort action in order to get an appropriate share. Alternatively, the State could intervene in the case and represent its own interests directly.

Letter from Health Care Financing Administrator to All State Medicaid Directors (June 5, 1996), Pet. App. A-237 to 238.

In addition, as part of the State Medicaid Manual issued to all States, CMS has interpreted the requirement in Section 1912 that a Medicaid recipient "cooperate" in pursuing third party recovery to include the responsibility to pay "any support or medical care funds received" that are covered by the assignment of rights to the Medicaid agency. Manual § 3905.3. The agency has also interpreted Section 1912(b) of the Act to mean that "[i]n liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award." The legitimate costs of obtaining a settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program. Manual § 3907.

CMS will "disallow" or take back federal funds if the State is found not to have complied with the statute's TPL provisions. In 1994, CMS disallowed $7.5 million in federal financial participation that California has claimed in its Medicaid program because Medi-Cal (California's name for

Medicaid) allowed recipients to retain at least 50% of any settlement or award from a third party tortfeasor. CMS interpreted the statute's assignment and TPL provisions to mean that where a third party or casualty insurer is responsible for paying a recipient's medical expenses, the recipient may not recover money for him or herself unless and until the federal government is reimbursed for its expenditures for the recipient's medical care.

As permitted under federal Medicaid regulations, California appealed the disallowance to the Departmental Appeals Board within the Department of Health and Human Services. The Board held that CMS's position was "directly supported" by the TPL and assignment provisions found in Sections 1902(a)(25) and 1912 of the Act. DAB No. 1504, *California Dep't of Health Servs.*, Pet. App. at A-202. The Board rejected California's argument that the distribution methodology of Section 1912(b) did not apply to situations where the award had been secured by the recipient. It reasoned that "[t]o allow the distribution of a settlement or an award to turn on whether a recipient or a state initiated the liability action would distort the Medicaid TPL system." Pet. App. at A-206.

The Board also rejected California's argument that CMS could not assume that the totality of a settlement or award was covered by Section 1912's assignment to payment "for medical care." The Board concluded that the federal agency "reasonably insisted on its right to characterize recoveries from third parties first as payments for medical care." Pet. App. at A-A-207. As the Board explained:

> This characterization prevents manipulation of tort awards by recipients who seek to prevent the public from being reimbursed for the funds it has advanced for their medical care (e.g., by suing for pain and suffering or

> lost wages rather than medical costs). Without it, TPL recoveries would be subject to a wide range of interpretations about what was appropriately considered payment for medical care.

Id. The Board held that CMS's interpretation was consistent with "Congress' intent, as evidenced by the terms of the Act, that the Medicaid program be fully reimbursed for its expenses before the victim shares in a TPL recovery." Pet. App. at A-208.

The Board reiterated these conclusions the following year in an appeal from a disallowance against the Washington State Department of Social and Health Services for amounts that CMS determined the State should have collected from TPL settlements and awards received by Medicaid recipients. *See* DAB No. 1561, *Washington State Dep't of Social and Health Servs.*, Pet. App. A-214. The Board again held that CMS's position that a Medicaid recipient may not recover money until the federal government is reimbursed for its expenditures was a reasonable interpretation of the statute and did not mean that the recipient assigns or loses his/her right to seek compensation for injuries beyond the cost of medical care:

> [CMS] reasonably read the Act to condition the availability of Medicaid funds on the recipient's agreement to reimburse Medicaid to the extent of a third party's liability. Therefore, Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient on the condition that it would be reimbursed if there was a liable third party from whom a recovery was collected.

Pet. App. at A-221.

D. Other Courts Also Disagree With the Minnesota Supreme Court's Interpretation.

In light of the statutory language, the legislative history establishing Medicaid as the payor of "last resort," and the agency's consistent interpretations, until now every court to address the question has concluded that Section 1917's general prohibition on liens on the "property" of a Medicaid recipient is not implicated by state laws that impose liens or subrogation rights on a personal liability award or settlement. *See Wilson v. State*, 10 P.3d 1061, 1066 (Wash. 2000), *cert. denied*, 532 U.S. 1030 (2001) (holding that because the lien is placed on personal injury settlement proceeds "before it become property of the Medicaid recipient . . . the department does not have a lien on 'property' of the recipient"); *Wallace v. Jackson*, 972 P.2d 446, 448 (Utah 1998) ("[P]ayments made by a third party do not legally become the property of the recipient until after a valid settlement which must include reimbursement to the State for Medicaid benefits."); *Cricchio v. Pennisi*, 683 N.E.2d 301, 305 (N.Y. 1997) (same); *see also Sullivan v. County of Suffolk*, 174 F.3d 282, 285 (2d Cir.), *cert. denied*, 528 U.S. 950 (1999) ("[These] liens enjoy a specific exemption from the general rule that the state may not encumber a Medicaid recipient's property prior to death.").

Similarly, until now, the courts have been in agreement that a Medicaid recipient cannot preclude Medicaid's recovery of funds from a third party award or settlement by characterizing the claim as one other than for medical care. *See In re Kietur*, 752 A.2d 799 (N.J. Super. Ct. App. Div. 2000) (all proceeds from medical malpractice settlement are subject to State's claim for Medicaid reimbursement, even where settlement funds are designated for pain and suffering and future needs); *Whelan v. Division of Med. Assistance*, 694 N.E.2d 10, 12 (Mass. Ct. App. 1998)

(plaintiff cannot avoid Medicaid's distribution by claiming that the settlement funds in question were for future medical costs; such a reading would permit for "easy subversion of the [federal-state] statutory purpose" by allowing attorneys to "ignore previous loss and demand of the third party only prospective loss."); *Grayam v. Dep't of Health and Human Servs.*, 201 W. Va. 444, 451, 498 S.E.2d 12, 19 (W. Va. 1997) (state law gives states a priority subrogation right to recover full reimbursement from any settlement or judgment against a liable third party).

For the great majority of States, however, these questions have not been settled, and the theory espoused by the Minnesota Supreme Court is certain to be advanced elsewhere, creating uncertainty and additional expense in the administration of third party recovery programs within State Medicaid agencies.

II. The Decision Cannot Be Reconciled With The Cost Recovery Schemes In Other Federal Benefits Statutes.

The underlying premise of the Minnesota court's decision is that a claim for medical care costs must be segregated from any correlated personal injury claims—the former to be pursued by the State (and only the State), and the latter remaining the "property" of the Medicaid recipient protected by the anti-lien provision, with no priority given to the State's claim. As the dissenting opinion points out, that fundamental premise is belied by the distribution scheme in Section 1912(b)—under this "each to his own" scenario, there would be no need for such a distribution—and is directly contrary to federal agency's interpretation of the statute, as reflected in and supported by the Departmental Appeals Board decisions in the *California* and *Washington* cases.

In addition, that approach is one that has been rejected by this Court and other federal courts when

construing the cost recovery provisions in other federal benefit statutes. This Court has previously had occasion, in the context of the Federal Employees' Compensation Act ("FECA"), 5 U.S.C. § 8101 *et seq.*, to recognize the federal cost recovery statutes must be construed in light of their purpose. *See, e.g., United States v. Lorenzetti*, 467 U.S. 167 (1984). FECA provides a comprehensive system of compensation, in the form of lost wages and medical costs, for federal employees who sustain work-related injuries. The statute provides that if an accident creates a legal liability on the part of a third party to pay damages, and a beneficiary receives money or other property as the result of suit or settlement, "the beneficiary, [after deducting legal expenses], shall refund to the United States the amount of compensation paid by the United States . . . ." 5 U.S.C. § 8132.

In *Lorenzetti*, a federal employee sought a declaratory judgment that the federal government's right of reimbursement of FECA benefits from a settlement was confined to damage awards for the lost wages and medical costs covered by FECA, thus precluding the government from recovering monies denominated as compensating non-economic losses. *See* 467 U.S. at 171. This Court unanimously agreed with the district court that "[t]here is no language in Section 8132 delineating two classes of damages—one of which gives rise to a duty to reimburse and one of which does not." *Id.* at 172 (citing *United States v. Lorenzetti*, 550 F. Supp. 997, 999 (E.D. Pa. 1982) (internal quotation marks and additional citation omitted)). In so holding, the Court noted that the FECA reimbursement section was adopted "'not for the purpose of increasing compensation, but for the purpose of reimbursing the Government for payments made and indemnifying it against other amounts payable in the future.'" *Id.* at 176 (quoting *Dahn v. Davis*, 258 U.S. 421, 430 (1922)).

The structure and history of third-party recovery under the Medicare statute provides further evidence that Congress did not intend recovery of Medicaid expenditures to be circumscribed by the nature of the damages alleged. As first enacted, Medicare served as the primary payor for medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan or liability insurance. Responding to skyrocketing medical costs, Congress in 1980 began to enact reforms that are collectively referred to as the Medicare Secondary Payer ("MSP") provisions. These provisions require Medicare to recoup payment where other sources of benefits are available. *See* 42 U.S.C. § 1395y(b).

Under the MSP provisions, when Medicare has information that medical care is needed because of an injury or illness caused by a third party, the program makes a "conditional payment." *See* 42 U.S.C. § 1395y(b)(2)(B)(i). Where such a payment is made, the government may bring a direct action to recover payment and has a right of subrogation for medical care payments made under Medicare. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii),(iii). The government need not prosecute its own action but can recover from a judgment against or settlement with a tortfeasor. *See Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997); *United States v. Sosnowski*, 822 F. Supp. 570 (W.D. Wis. 1993).

When suit is brought by a Medicare recipient, the courts have rejected the notion, critical to the conclusion of the Minnesota Supreme Court, that Medicare's right to recovery is dependent on the plaintiff's characterization of damages. In *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995), the Ninth Circuit rejected plaintiffs' argument Medicare was limited to a pro rata share of a settlement rather than the actual cost of the items or services for which the program had paid. *Id.* at 844. The court noted that limiting recovery would be inconsistent with the purpose of the MSP

legislation, and it rejected the contention that HHS should be limited by the victim's calculation of damages. *See id.* at 845-46. In so doing, the Ninth Circuit noted that such an interpretation of the recovery statute "would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages." 67 F.3d at 846.

"As a matter of common sense," the payor of last resort must be able to "recover to the extent that the third party is liable for the services and to the extent that Medicaid actually paid for the services." *James Square Nursing Home, Inc. v. Wing*, 897 F. Supp. 682, 687 (N.D.N.Y. 1995). The decision below defies common sense by making Medicaid a payor of last resort only if States expend scarce resources to separately pursue claims for medical reimbursement rather than use the system of lien and/or subrogation rights that many States have in place. It is not faithful to the statutory intent, unreasonably departs from the considered view of the federal agency tasked with implementing the statute, and creates uncertainty in an important area of program administration.

CONCLUSION

For all of these reasons, as well as those set forth in the petition, *amici* respectfully urge the Court to grant the petition for certiorari to review both questions presented in this case.

Respectfully submitted,

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